

# OPTIMA FAMILY CARE MEDALLION 4.0

## PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST\*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-844-723-2094. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete forms will delay the authorization process.

**Drug Requested:** Elelyso® (taliglucerase alfa) (Injection for IV use) (*Medical*)

**DRUG INFORMATION:** Complete all information below or authorization process will be delayed.

Drug Form/Strength/Quantity per Day: \_\_\_\_\_

Dosing Schedule: \_\_\_\_\_ Length of Therapy: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code, if applicable: \_\_\_\_\_

**CLINICAL CRITERIA:** To receive a one year approval for this drug, ALL appropriate boxes below must be checked to ensure authorization process will NOT be delayed.

Does member meet the following criteria?

- Is member using this for long-term enzyme replacement therapy with a confirmed diagnosis of Type 1 Gaucher disease?  Yes  No
- Is member 18 years of age or older?  Yes  No

**Medication to be provided by:** (Please check applicable box below.)

Physician's office **OR**  Specialty Pharmacy: PropriumRx

**\*\*Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.\*\***

**\*Previous therapies will be verified through pharmacy paid claims or submitted chart notes.\***

Patient Name: \_\_\_\_\_

Member Optima #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

DEA OR NPI #: \_\_\_\_\_